

UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2017
QUALITY IMPROVEMENT INCENTIVE (2)(i) APPLICATION
Improve Nurse Call System, Rule R414-504-4

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2017

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility paid for a new nurse call system or enhancements to its existing nurse call system by May 31, 2017 and installed or enhanced it between July 1, 2015 and May 31, 2017.
- ☐ The nurse call system is compliant with approved "Guidelines for Design and Construction of Health Care Facilities."
- ☐ The nurse call system does not primarily use overhead paging; rather a different type of paging system is used. The paging system could include pagers, cell phones, Personal Digital Assistant devices, hand-held radio, etc. If radio frequency systems are used, consideration has been given to electromagnetic compatibility between internal and external sources.
- ☐ The nurse call system is designed so that a call activated by a resident will initiate a signal distinct from the regular staff call system and that can be turned off only at the resident's location.
- ☐ The signal activates an annunciator panel or screen at the staff work area or other appropriate location, and either a visual signal in the corridor at the resident's door or other appropriate location, or staff pager indicating the calling resident's name and/or room location, and at other areas as defined by the functional program.
- ☐ The nurse call system is capable of tracking and reporting response times, such as the length of time from the initiation of the call to the time a nurse enters the room and answers the call.
- ☐ All of the following documentation is attached:
- ☐ A signed statement by the facility administrator stating that the nurse call system is compliant with approved "Guidelines for Design and Construction of Health Care Facilities."
- ☐ A detailed description of the functionality of the nurse call system, attesting to its meeting all of the above criteria;
- ☐ Detailed supporting documentation of the facility's nurse call system costs, installation and training costs; and Proof of purchase that includes receipts and invoices. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc. Check amounts must match receipt and invoice amounts. If the check does not match the receipt or invoice amount, an itemized list of invoices paid by the check must be provided with one entry matching the amount of the receipt or invoice for which the facility is seeking incentive payments.

Qualifying facilities may receive up to \$391 per Medicaid Certified bed (count as of 7/1/2016) under this incentive. This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is \$589.94 per Medicaid Certified bed (count as of 7/1/2016). Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures

Total Reimbursement Requested (should match spreadsheet): \$ _____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.

By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify. Fax to: 801-237-0788 <or> Mail instructions: <http://health.utah.gov/medicaid/stplan/longtermcare.htm>